Independent Assessment Guidelines

The State's Medicaid UR vendors shall provide data to DHHS through regularly scheduled operation reports. The DMA/DMH Quality of Care (QOC) Committee shall utilize the data within the reports to identify providers with high denial/appeal rates (those that exceed identified benchmarks) as well as a high number of cases of concern and quality of care referrals.

The QOC Committee will contact the LME to conduct a clinical chart review. The LME shall complete the review and report back to the QOC Committee within 45 days.

Per authorization from DHHS, the LME clinical staff shall review charts for the following:

- Quality of the clinical assessment – that it was completed in compliance with IU #36
- Based on the assessment, review the PCP to determine:
    - That the level of care is appropriate
    - Have appropriate referrals been made
        - For services
        - For additional evaluations/assessments
        - To informal supports
    - Are the services ordered in accordance with PCP guidelines and consistent with best practice guidelines

Per authorization from DHHS, based on the results of the audit the LME shall consider one or more of the following:

- Provide technical assistance to the provider (inclusive of targeted training on the service array, service definitions, and best practice as indicated)
- Require a Plan of Correction
- Refer for further monitoring/investigation
    - LME Targeted Monitoring
    - DMA Program Integrity
    - DMHDDSAS Accountability
    - DHSR Mental Health Licensure
    - DSS Licensure
- Withdraw endorsement

Results of the review are reported to DMA Program Integrity for tracking

<u>Assessments for Recipients of Selected Enhanced Services</u>

Medicaid recipients identified by the UR vendor as meeting any of the criteria below may be referred to the LME Care Coordination. The LME shall work with the recipient and recipient's provider of record to arrange for the recommended assessment. Each referral shall be identified as a:

- case of concern (e.g., a question regarding appropriateness of treatment or identification of a recipient who utilizes multiple crisis services within a 6 month period), OR
- quality of care issue, OR
- level of care review, e.g., Medicaid recipients
    - Who have been receiving ACTT services for a period of 18 months and for whom the intent is to continue services beyond the 18 months, **OR**
    - Who have been receiving PSR services for a period of 18 months and for whom the intent is to continue services beyond the 18 months, **OR**
    - Who have been receiving IIH services for a period of 6 months and for whom the intent is to continue services beyond the 6 months, **OR**
    - Who have been receiving Day Tx services for a period of 6 months and for whom the intent is to continue services beyond the 6 months, **OR**

- Who have been receiving MH/SA TCM services for a period of 7 months and for whom the intent is to continue services beyond the 7 months, **OR**
- Who have been in out of home placement for a period of 12 months and for whom the intent is to continue services beyond the 12 months, **OR**
- Who have a request for out of state placement submitted or who have been in out of state placement for a period of 12 months and for whom the intent is to continue services beyond the 12 months

The UR vendor shall specify the type of concern as well as make recommendations for follow-up.

Per authorization from DHHS, the LME follow shall consider one or more of the following:

- Working with the provider of record to arrange the recommended assessment for the identified Medicaid recipient
- Technical assistance for the provider
- Plan of Correction
- Referral for further monitoring/investigation
    - LME Targeted Monitoring
    - DMA Program Integrity
    - DMHDDSAS Accountability
    - DHSR Mental Health Licensure
    - DSS Licensure
- Withdrawal of endorsement

The LME shall follow up and report findings to DMA program integrity. The findings shall include the name of the LME, the identifying information for the case, the date of receipt by the LME, the action taken by the LME, the required provider action, the date closed (or proposed date for closure).

If a medication evaluation is determined to be required, the evaluation shall be completed by a psychiatrist who specializes in the age/disability of the Medicaid recipient. The medication evaluation must be completed (evaluation and the report) as soon as clinically indicated (based upon immediacy of need), but no later than 28 calendar days of the identification of the need for the evaluation.

If a full assessment is determined to be required, it must be a Comprehensive Clinical Assessment (CCA) per IU #36. Assessment shall be completed (evaluation and the report) as soon as possible but no later than within 30 calendar days of the identification of the need for an independent assessment.

Assessment (CCA, medication evaluation or other) must be performed by a qualified provider, OTHER THAN

- the ACTT, CST, PSR, IIH, MH/SA TCM, Day Tx, residential or out of state provider **AND**
- any agency in which ACTT, CST, PSR, IIH, MH/SA TCM, Day Tx, residential or out of state provider's employees have an interest* **AND**
- if the referral for the independent assessment of any type is due to a quality of care concern, the independent assessment must be completed by a provider **other than** the current provider or any provider in which the current provider's employees have an interest*
- Note: a provider of the crisis service such as the walk-in clinic or the Mobile Crisis Management (MCM) provider may complete the assessment. (This is the one activity that MCM licensed clinicians may perform outside of MCM duties in the event that the revised service definition is adopted.)

If the LME receives a referral for a recipient that has had an independent assessment completed within the past six (6) months, the licensed LME staff shall review the previous assessment and other

documentation available to determine whether all of the MH/DD/SA recommendations have been implemented.

- If all recommendations from the previous assessment have NOT been implemented the licensed LME staff shall assist the recipient in obtaining all necessary referrals.
- If the recommendations from the previous assessment have been implemented, the licensed LME staff shall review documentation to determine whether current services meet the needs of the individual.
    - If services recommended in the assessment continue to be clinically indicated, the licensed LME staff shall assist the current provider and the recipient in reviewing the PCP to determine that the interventions are meeting the needs of the recipient. If revisions to the PCP are indicated, they shall be completed utilizing the person centered planning process and/or the Child and Family Team.
    - If the licensed LME staff determines that there is a question whether the services are clinically indicated, the licensed LME staff shall schedule the additional independent assessment.

The disposition shall include the recommended type and amount MH/DD/SA services (frequency and intensity) and identify other referrals necessary to meet the individual's needs (e.g., primary care physician for physical health needs, additional evaluations, informal supports).

The provider completing the assessment shall provide a copy of the assessment to the current provider and the LME involved in the referral after obtaining the required recipient consent for release/exchange of information.

- Assessing provider shall discuss the findings of the assessment with the LME, the current provider and the recipient.
- The current provider shall address all recommendations in the disposition of the assessment, including revising, with the recipient, the Person Centered Plan if indicated.
- If referral outside the current provider agency is necessary for any of the recommendations in the assessment, provider choice guidelines shall be followed.

The current provider shall assist the consumer in following up on all necessary referrals made as a result of the independent assessment.

*Interest – having a familial or financial relationship** with the provider agency or any of its investors, owners, board members or employees.

**Financial relationship – contractual or employment arrangement; arrangement involving a commission, reward, or other financial, material or tangible consideration or benefit.

Disputes shall be handled through the Medicaid appeals process, if applicable.